

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07978 Item #8 & 9 Film #9389 6/15/67 07952											
1. PLACE OF DEATH a. COUNTY CARROLL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG RD#1						c. LENGTH OF STAY IN 1b 50 YRS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #140						d. STREET ADDRESS Route #140					
3. NAME OF DECEASED (Type or print) First JOHN Middle PRESTON Last ALBAUGH						4. DATE OF DEATH Month JUNE Day 7 Year 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 JULY 25, 1887		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN THOMAS ALBAUGH						14. MOTHER'S MAIDEN NAME MILLIE ABERILLA HANN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. 220-09-6095A		17. INFORMANT MISS H. MADELINE ALBAUGH				Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/10 , 19 49 , to 6/7 , 19 67 , that (I) (we) last saw the deceased alive on 6/1 , 19 67 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE Julius Chepko						22b. DATE SIGNED 6/7/67					
22c. PHYSICIAN'S NAME (Type) Julius Chepko MD						22d. ADDRESS 858 W. Green St Westminster MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/10/67		23c. NAME OF CEMETERY OR CREMATORY BETHEL (CARROLLTON) CEM				23d. LOCATION (City, town or county) (State) FINKSBURG RD#1 MD.			
24. FUNERAL DIRECTOR J. E. Smyth Jr. WESTMINSTER, MD 21157						25a. REC'D BY REGISTRAR June 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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RECEIVED FROM JOHN WHITE JULY 25 1875

PAID TO JOHN WHITE JULY 25 1875

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PAID TO JOHN WHITE JULY 25 1875

07979

CERTIFICATE OF DEATH

07963

1. PLACE OF DEATH a. COUNTY <i>Springfield State Hospital</i>		USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto. City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
c. LENGTH OF STAY in lb <i>1 yr. 2 mo. 7 da.</i>		d. STREET ADDRESS <i>3615 Yolando Rd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Springfield State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George Mooter BALL</i>		4. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>1967</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7-26-85</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	9. AGE (In years last birthday) <i>81</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>KENTUCKY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Mooter Ball</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Springfield Record</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral atherosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome assoc. with senile brain disease without qualifying phrase</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5-16</i> , 19 <i>66</i> , to <i>6-9</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-8</i> , 19 <i>67</i> , and that death occurred at <i>3</i> P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>Mario E. Comas</i>		22b. DATE SIGNED <i>6-9-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>MARIO E. COMAS</i>		22d. ADDRESS <i>1302 KENSEL CT. BALTO MD.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>6-14-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Cincinnati Ohio</i>
24. FUNERAL DIRECTOR <i>Nancy W. Haight</i>		25a. RECEIVED BY REGISTRAR <i>Sykesville, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		JUN 15 1967	

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07370

CERTIFICATE OF DEATH

07370

DATE OF DEATH: 1944

TIME OF DEATH: 1944

PLACE OF DEATH: 1944

CAUSE OF DEATH: 1944

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07980

CERTIFICATE OF DEATH

07964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 104 N. Summit Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Edward Biddinger		4. DATE OF DEATH Month Day Year 6 - 15 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 15 19 67	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		11b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bradley Biddinger		14. MOTHER'S MAIDEN NAME Virginia Eaves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-38-8851	
17. INFORMANT Springfield Hospital Records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retro-peritoneal hemorrhage DUE TO (b) Perforated abdominal aorta aneurysm DUE TO (c) 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to June 15, 1967 , that (X) (we) last saw the deceased alive on June 15, 1967 , and that death occurred at 2:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 6-15-67	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-19-67	23c. NAME OF CEMETERY OR CREMATORY Union Chapel	23d. LOCATION (City or town) (County) (State) Frederick Co. Maryland
24. FUNERAL DIRECTOR Ernest C. Gartner		25a. REC'D BY REGISTRAR 19 1967	
ADDRESS Ernest C. Gartner, Gaithersburg, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

STATE OF TEXAS

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CERTIFICATE OF DEATH

07965

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY in 1b 4 mths-15 d.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS Faharney Kneedy Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ethel Irene Bingham			4. DATE OF DEATH Month June Day 17 Year 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-88		9. AGE (In years last birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress		10b. KIND OF BUSINESS OR INDUSTRY Postal	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David H. Bingham			14. MOTHER'S MAIDEN NAME Merryman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-48-0308	17. INFORMANT Records Address Springfield State Hospital Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 715X DUE TO (b) Terminal Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Infected Decubitus Ulcers					INTERVAL BETWEEN DEATH AND DEATH Days Days Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2-2- , 19 67 to 6-17- , 19 67 , that (I) (we) last saw the deceased alive on 8-17- , 19 67 , and that death occurred at 10:05 am , from causes and on the date stated above.					
22a. SIGNATURE <i>Naci D. B. Bingham</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 17, 1967		
22c. PHYSICIAN'S NAME (Type) Naci D. B. Bingham, M. D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/20/67	23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	23d. LOCATION (City or Town) (County) (State) Knoxville Maryland		
24. FUNERAL DIRECTOR Fete Funeral Home		ADDRESS Burawick, Md.		25a. REC'D BY REGISTRAR DATE JUN 20 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2015/10/27 09:22:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07982						07986					
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u> c. LENGTH OF STAY IN ID <u>11 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKFIELD MANOR NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KEYMAR</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL ELLIS BOHN</u>						4. DATE OF DEATH Month Day Year <u>JUNE 25 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 1 - 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GRANT BOHN</u>						14. MOTHER'S MAIDEN NAME <u>ROSA KOONS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-32-4119</u>				17. INFORMANT Address <u>THEO BOHN KEYMAR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>191X</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atherosclerosis + thrombosis ③ left hemiparesis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>6/25/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/25/67</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>J. H. Caricofe</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/25/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J H CARICOFE</u>						22d. ADDRESS <u>UNION BRIDGE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>6/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT UNION</u>		23d. LOCATION (City, town or county) (State) <u>UNION BRIDGE RURAL MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler</u> ADDRESS <u>Union Bridge, Md</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07983

07967

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 10 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mineral Hill Road, Box 234				e. STREET ADDRESS Mineral Hill Road, Box 234			
3 NAME OF DECEASED (Type or print) RUSSELL B. BRASHEAR				4 DATE OF DEATH Month June Day 2 Year 1967			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Aug. 24, 1893	
9 AGE (In years lost birthday) yrs 73		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME ? Brashear			
14 MOTHER'S MAIDEN NAME Annie Siemon				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO 212-07-5550				17 INFORMANT Address Mrs. Elsie Brashear - Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				22. DATE SIGNED 6/3/67			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				22. DATE SIGNED 6/3/67			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b DATE THEREOF 6-5-67		23c NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery	
23d LOCATION (City or Town) _____ (County) _____ (State) _____ Mt. Airy, Md.				24 FUNERAL DIRECTOR Harry W. Haight		25a REC'D BY REGISTRAR Jun 7 1967	
25b REGISTRAR'S SIGNATURE Richard Judge							

07984

CERTIFICATE OF DEATH

07963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>2 mo. 8 d.</u>		d. STREET ADDRESS <u>Rt #3, Clapper Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy MAE BROWN</u>		4. DATE OF DEATH <u>JUNE 3 1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/20/84</u>
9. AGE in years (last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>13</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN - Seckford</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>Springfield Hospital Records, Sykesville, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 473X DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS Assoc. with senile brain disease with psychotic reaction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3-26-67, 1967</u> , to <u>6-3-1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6-3-1967</u> , and that death occurred at <u>1039 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>NACIN B. YUKUNSAI, M.D.</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>NACIN B. YUKUNSAI, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Md. 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rileyville</u>	23d. LOCATION (City or Town) (County) (State) <u>Rileyville, Va.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>Pike</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 8 1967</u>			

07985

CERTIFICATE OF DEATH

07969

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>	
c. LENGTH OF STAY IN 1b <u>24 DAYS</u>		d. STREET ADDRESS <u>R 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>PAULINE MAUDE CONAWAY</u>		4 DATE OF DEATH <u>JUNE 27 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>OCT 28 - 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINE OPERATOR</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>JOHN H DILLER</u>		14 MOTHER'S MAIDEN NAME <u>CARRIE HALE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>213-16-0945</u>	
17. INFORMANT <u>ALVA CONAWAY</u> Address <u>R 1 UNION BRIDGE MD</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEART</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Juvenile arterial system</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> , 19 <u>67</u> , to <u>June 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> , 19 <u>67</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		22b. DATE SIGNED <u>6/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>7 Archer St Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>	23d. LOCATION (City or Town) (County) (State) <u>JEFFERSON MD</u>
24 FUNERAL DIRECTOR <u>DD Hartzler & Sons Union Bridge</u>		25a. REC'D BY REGISTRAR <u>June 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07986

07200

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Maryland</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <u>Westminster</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b <u>25 YRS.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>208 PENNA. AVE.</u>						e. STREET ADDRESS <u>208 PENNA. AVE.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWARD FARVER</u>						4. DATE OF DEATH Month Day Year <u>JUNE 16 1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 18, 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TURN KEY, PRISON</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>JACOB FARVER</u>						14. MOTHER'S MAIDEN NAME <u>ELIZA JANE YOUNG</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>216-01-9979</u>					
17. INFORMANT Address <u>Son Mrs. Emma B. Newkome</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> <u>General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Atherosclerosis General</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>64</u> to <u>6/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> , 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William Spercher</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/17/67</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>NEW WINDSOR RD MD.</u>			
24. FUNERAL DIRECTOR <u>J. S. Myerhoff, Westminster, Md.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

100

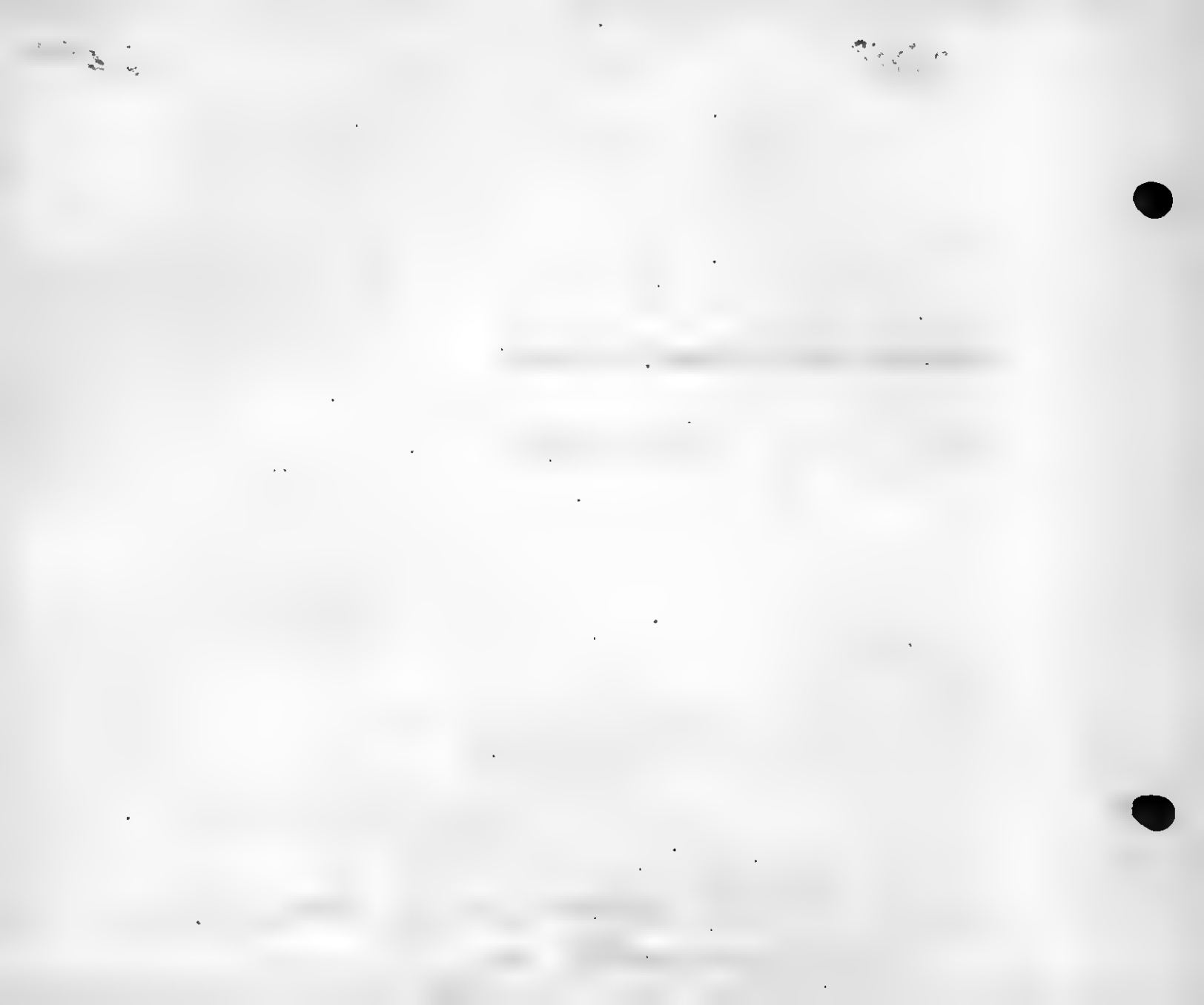


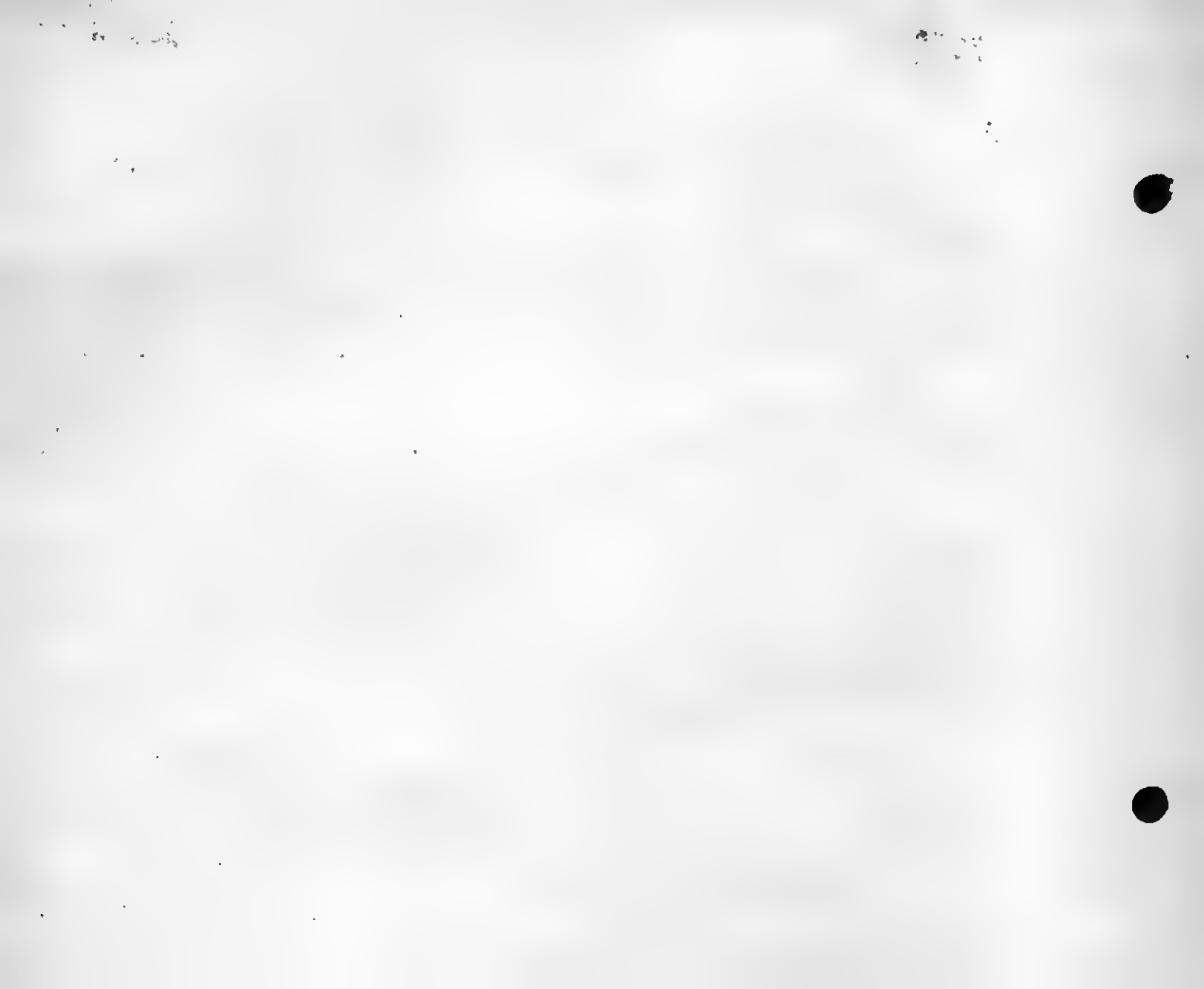
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>George Viner Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md</u> d. STREET ADDRESS <u>118 Willis</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Ellicott</u> Last <u>George</u>						4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 7 - 1889</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHOLESALE MEAT PACKING CO. (OWNER)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co, Md</u>				11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSIAS GEORGE</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Jenkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>						16. SOCIAL SECURITY NO. <u>216-03-7759</u>		17. INFORMANT <u>Edith George</u> Address <u>118 Willis Westminster, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertrophosis left kidney</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (b) (this hospital) attended the deceased from <u>6/24</u> , 1967, to <u>6/30</u> , 1967, that (b) (we) last saw the deceased alive on <u>6/26</u> , 1967, and that death occurred at <u>5P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W H Howard</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. FORD, M.D.</u>						22d. ADDRESS <u>Manchester, Md 21102</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>7/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u>			
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr.</u>						ADDRESS <u>Westminster, Md</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>21157</u>	
DATE <u>JUL 5 1967</u>											





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07989

Item #3 ref. from burial cert. 7/27/67 pc

CERTIFICATE OF DEATH

07973

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospt.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead d. STREET ADDRESS Rt. 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Deborah Lynn Jo Ann F./				4. DATE OF DEATH June 18 1967		5. AGE (In years last birthday) 3		6. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1967		9. AGE (In years last birthday) 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Groomes				14. MOTHER'S MAIDEN NAME Jo Ann E. Cramens					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT William Groomes Address Rt. 2 Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypoplasia DUE TO (b) Congenital Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pierre-Robin Syndrome								INTERVAL BETWEEN ONSET AND DEATH Congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.									
22a. SIGNATURE D. A. Knight M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		June 19, 1967		Lorraine Park Cemetery		Woodlawn Balto. Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Tipton - Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR JUN 21 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

W. 33



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07990					07974				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
e. COUNTY		Carroll			e. STATE		b. COUNTY		
		MARYLAND			Maryland		Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Mt. Airy					Mt. Airy				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
R.F.D. # 3					R.F.D. # 3				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Harry E. Hahn					June 28 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 3, 1909		58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Auto Dealer					Mt. Airy, Md.			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles Hahn					Alverta Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
No					214-34-2815		Mrs Lynda Watkins Hahn, Item 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Rectum</u>									
154X DUE TO									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1967</u> to <u>June 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1967</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>W.B. Lilwell</u> M.D.									
22b. DATE SIGNED <u>6/28/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>W.B. Lilwell</u>									
22d. ADDRESS <u>900 So. Main St Mt. Airy, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>July 1, 1967</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>									
23d. LOCATION (City, town or county) (State) <u>Mt. Airy, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>									
25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>									
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07991

CERTIFICATE OF DEATH

07975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll County Westminister DOA c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3005 Milford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Wheeler Knight Hancock			4 DATE OF DEATH Month June Day 1 Year 1967				
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8 DATE OF BIRTH 1896		9 AGE (In years last birthday) 70 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fire fighter			
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Pillar Point, New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank B. Hancock			14. MOTHER'S MAIDEN NAME Knight				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO		17 INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Myocardial infarction with DUE TO (c) Coronary insufficiency Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April , 19 62 , to death, 19 67 , that (I) (we) last saw the deceased alive on May 9 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <i>Joseph D'Antonio</i>			22b. DATE SIGNED June 3, 1967		22c. PHYSICIAN'S NAME (Type) Joseph D'Antonio, M.D.		
22d. ADDRESS 100 N. Broadway			22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			
23d. LOCATION (City or town) (County) (State) Baltimore, Maryland		23e. FUNERAL DIRECTOR Ellsworth Armacost 4600 Liberty Hghts. Ave.					
24. REC'D BY REGISTRAR DATE JUN 5 1967		25. REGISTRAR'S SIGNATURE <i>William J. [unclear]</i>					



FOR STATE
HEALTH DEPT.

07992

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07976

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY (In days) 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 21701 d. STREET ADDRESS 352 Park Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Agnes Florann Hargett		4 DATE OF DEATH Month June Day 26 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-26-31
9 AGE (In years lost birthday) yrs 35		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Paul C. Welty, Sr.		14 MOTHER'S MAIDEN NAME Anna Scott	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 214-28-0630	
17 INFORMANT Springfield State Hospital records		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the nasal passages and mouth by face being buried in a blanket. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 6/26/67	
23a BURIAL, CREMATION, or other disposal (Specify) Burial	23b DATE THEREOF 6-29-1967	23c NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d LOCATION (City or town) Frederick, Maryland
24 FUNERAL DIRECTOR Walters Funeral Home ADDRESS		25a REC'D BY REGISTRAR DATE JUN 28 1967	25b REGISTRAR'S SIGNATURE W. Glenn Speicher

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07993

CERTIFICATE OF DEATH

07977

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>1WK.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>		d. STREET ADDRESS <u>45 W. GREEN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM GILBERT HEAGY</u>		4. DATE OF DEATH Month Day Year <u>JUNE 16 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 1, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER SPORT GOODS STORE AND BARBER CARROLL CO. MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E. HEAGY</u>		14. MOTHER'S MAIDEN NAME <u>EMMA K. GARDNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-1082</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Heart Disease</u> (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 8, 1967</u> , to <u>June 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1967</u> and that death occurred at <u>12:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harsanyi</u>		22b. DATE SIGNED <u>6/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSANYI MD</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SANDY MOUNT CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>FINKSBURG RD MD.</u>
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

8-10-70

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07978

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster R.D. 4</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster R.D. 4</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>HELENA JANE MORSEY</i>		4. DATE OF DEATH Month <i>6</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 4, 1894</i>
9. AGE (In years and birthdays) <i>72</i> yrs		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>19</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>James H. Gray</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Mann</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>204-05-2248</i>	
17. INFORMANT <i>Mrs. Jean Spangler Finksburg, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Changes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Vascular Disease with</i> DUE TO (c) <i>decompensation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o.m.</i> <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. Glenn Peicher</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>6-24-67</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 28, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Park</i>		23d. LOCATION (City or town) (County) (State) <i>Carroll Co. Md.</i>	
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 28 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



07995

CERTIFICATE OF DEATH

07930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 13yr. 4days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3737 Keswick Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thelma Middle Victoria Last Irwin		4. DATE OF DEATH Month 6 Day 22 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/97
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earnest Evans		14. MOTHER'S MAIDEN NAME Raechael Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4:01 DUE TO (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, depressed type.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat'While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 6/18/ , 19 54 , to 6-22-1967 , that he (we) lost saw the deceased alive on 6-22-1967 , and that death occurred at 5 P.M. from causes and on the date stated above.			
22a. SIGNATURE Luis J. Ambas		22b. DATE SIGNED 6/22/67	
22c. PHYSICIAN'S NAME (Type) Luis J. Ambas, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 26 June 1967	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City or Town) (County) (State) Wheeling Ohio Co., West Va.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 28 1967	



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VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07996					07981						
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marriottsville</u>						
c. LENGTH OF STAY in 1b <u>9 days</u>					d. STREET ADDRESS <u>Marriottsville Road</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Edna</u> Last <u>Jaeger</u>					4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>						
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>						
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Feb. 20, 1928</u>						
9. AGE (in years last birthday) <u>39</u> yrs.					10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>						
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>Wm. P. Zopp</u>					14. MOTHER'S MAIDEN NAME <u>Lucille Arrington</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>-----</u>						
17. INFORMANT <u>Mr. George A. Jaeger</u>					Address <u>Marriottsville, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Terminal pneumonia</u> <u>32X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) <u>Cerebral accident</u> DUE TO (c) <u>Cerebral thrombosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2:00 p.m. 23 June 1967</u> to <u>2:00 p.m. 29 June 1967</u> that (I) (we) last saw the deceased alive on <u>23 June 1967</u> and that death occurred at <u>2:00 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Sam Guttman</u>					22b. DATE SIGNED <u>June 29, 1967</u>						
22c. PHYSICIAN'S NAME (Type) <u>Sam Guttman</u>					22d. ADDRESS <u>One Out ...</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Knight</u>					ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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VR A15 (4)
20M 1/65

07997

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07982

1. PLACE OF DEATH a. COUNTY <u>Cavall</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manassas</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown, Md.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>103 First Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Irene</u> Last <u>Koontz</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-89</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel B. Beck</u>		14. MOTHER'S MAIDEN NAME <u>Hannah H. Fassbender</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-48-0754</u>	
17. INFORMANT <u>John Koontz</u>		Address <u>Reisterstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive arteriosclerotic</u> DUE TO (c) <u>cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>5/20</u> 19 <u>67</u> , to <u>6/5</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>6/5</u> 19 <u>67</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Foard</u>		22b. DATE SIGNED <u>6/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H Foard MD</u>		22d. ADDRESS <u>Manchester, Md 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem Gardens</u>	23d. LOCATION (City, town or county) (State) <u>Finksburg, Maryland</u>
24. FUNERAL DIRECTOR <u>H. J. Eckhardt Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

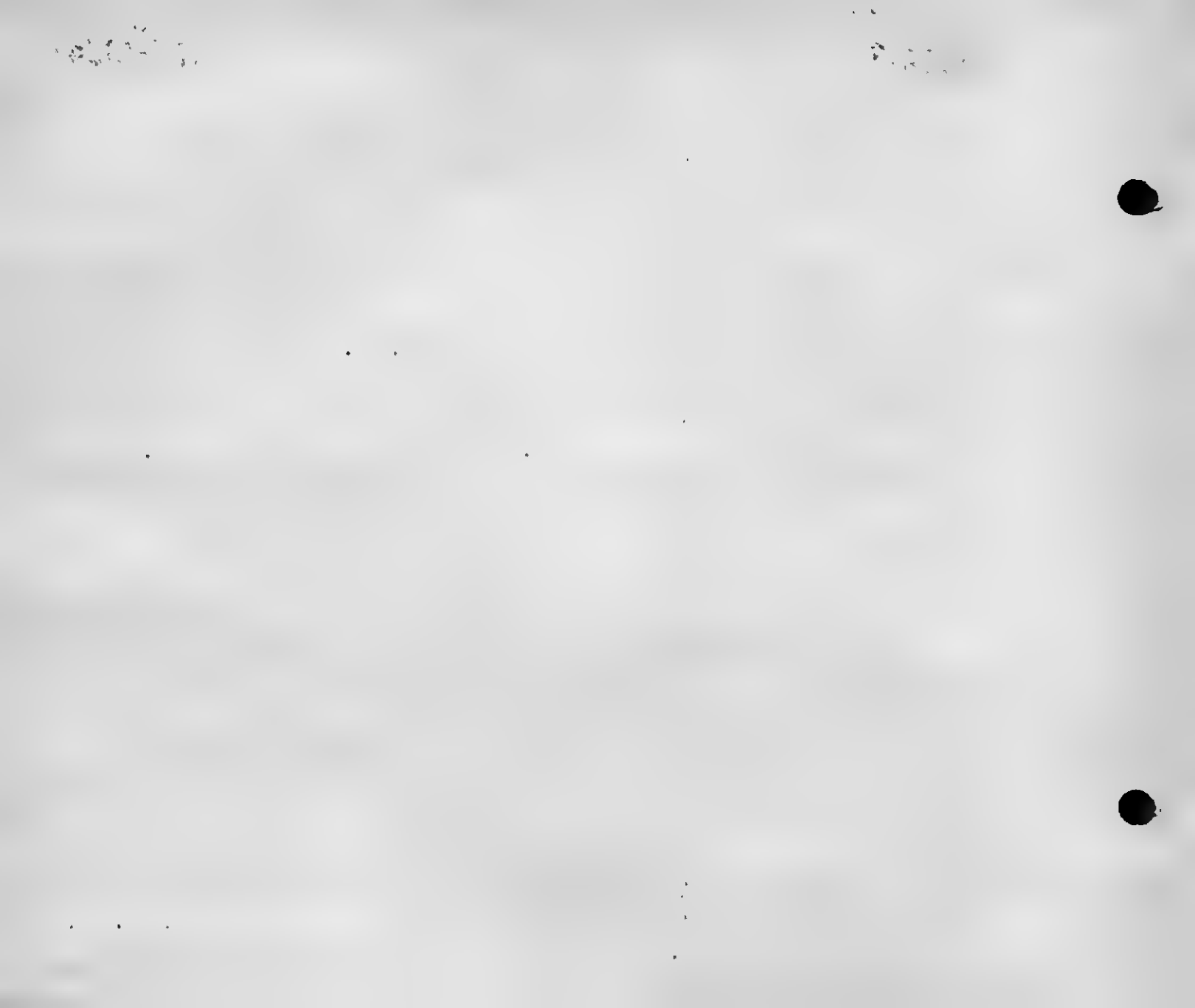
VR A15 (4)
ISM 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07998

07983

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1249 Battery Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Lacer</u>				4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 31 88</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Walter</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Thelma Zang</u> Address <u>1249 Battery Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident (hemorrhage)</u> DUE TO (b) <u>Arterio-sclerotic, Cardiovascular</u> DUE TO (c) <u>Disease, Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>15 yrs</u> <u>7</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 3, 1967</u> to <u>June 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1967</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Sani Okutman</u> M.D.				22b. DATE SIGNED <u>6.28.67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>				22d. ADDRESS <u>Sykesville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) <u>Brooklyn, A. A. Co., Md.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Cully</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u> </u>			
DATE <u>JUN 30 1967</u>							



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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07993

07984

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 4mo. 16days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1228 Tanley Road	
3. NAME OF DECEASED (Type or print) Elizabeth Mary Lamb		4. DATE OF DEATH Month 6 Day 6 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/82
9. AGE (In years, last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Guiser		14. MOTHER'S MAIDEN NAME Elizabeth Barry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 175-01-1324	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Rheumatic heart disease DUE TO (c) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH days years days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis without qualifying phrase.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 1/20/ , 1967, to 6/6/ , 1967, that he (we) last saw the deceased alive on 6/6/ , 1967, and that death occurred at 10:45 p.m. from causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal, M.D.		22b. DATE SIGNED 6/6/67	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-10-67	
23c. NAME OF CEMETERY OR CREMATORY Cabery Cemetery		23d. LOCATION (City or Town) (County) (State) Charlevoix PA.	
24. FUNERAL DIRECTOR Harry Warr Knight		25a. REC'D BY REGISTRAR DATE JUN 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

2011



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VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08000

07985

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>914 KENT AVE.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pullen Nursing Home</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maud</u> Middle <u>Lawrence</u> Last <u>Lawrence</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25, 1884</u> 9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ottawa Canada</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hall</u>		14. MOTHER'S MAIDEN NAME <u>Helen A. Lawrence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u> 17. ADDRESS <u>Helen A. Lawrence</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Memic Larrea</u> DUE TO (b) <u>Chronic heart failure</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>2 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-26-67</u> to <u>6-18-67</u> , that (I) (we) last saw the deceased alive on <u>6-17-67</u> , and that death occurred at <u>10:4</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Sani Okutman</u>		22b. DATE SIGNED <u>6-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Heemon Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Heemon New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amrose Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JUN 21 1967</u>	

100

100



07986

08001

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD.		c. LENGTH OF STAY IN lb 1 WEEK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GEN. HOSP.		e. STREET ADDRESS UNIONTOWN RD. BOX #106	
3. NAME OF DECEASED (Type or print) ALVA THEODORE LONG		4. DATE OF DEATH Month 6 - Day 23 - Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 29 1905
9. AGE (in years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE FACTORY FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING	
11. BIRTHPLACE (County & State, or foreign country) FRED COUNTY U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MESLEY LONG		14. MOTHER'S MAIDEN NAME VIRGINIA T. LONG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-05-5408 MFE.	
17. INFORMANT MRS. VIOLA C. LONG		Address RD #5 BOX 106 WESTMINSTER, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE DUE TO (b) PULMONARY DISEASE DUE TO (c) YEARS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/17 , 1967, to 6/23 , 1967, that (I) (we) last saw the deceased alive on 6/23 , 1967, and that death occurred at 1:42 P.M., from causes and on the date stated above.			
22a. SIGNATURE Vincent J. Fiocco		22b. DATE SIGNED 6/23/67	
22c. PHYSICIAN'S NAME (Type) VINCENT J. FIOCCO, MD.		22d. ADDRESS BANCHOR ST. WESTMINSTER, MD.	
23a. BURIAL CREMATION, (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6/26/67	EVERGREEN MEMORIAL	FINKSBURG CARROLL MD.
24. FUNERAL DIRECTOR James G. Saffell		25a. REC'D BY REGISTRAR DATE JUN 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08002

CERTIFICATE OF DEATH

07987

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN lb <u>11 mo. 24 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1721 Lafayette Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Dewey</u> First Middle Last <u>Madison</u>		4. DATE OF DEATH Month Day Year <u>6</u> <u>27</u> <u>19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-10</u> 9. AGE (In years lost birthday) yrs <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Madison</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO <u>Unkn.</u>	
17. INFORMANT <u>Springfield State Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism (source unknown)</u> DUE TO (b) <u>Right heart failure</u> DUE TO (c) <u>Hypertrophy of right and left ventricle muscles</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome of unknown cause with behavioral reaction</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> , 19 <u>66</u> , to <u>6-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-27-67</u> , 19 <u>67</u> , and that death occurred at <u>9:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Heinz Klaatsch</u>		22b. DATE SIGNED <u>6-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Heinz Klaatsch, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REPOSSITION <u>buried</u>		23b. DATE THEREOF <u>7/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sykesville, Maryland A A County Md</u>	
24. FUNERAL DIRECTOR <u>Halstead Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

07938

08003

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN b. <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>26 S. Church Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>26 S. Church Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROY MILTON MANN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1967</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 12, 1905</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mill work</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Congoleum Nairn</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. William Mann</u>		14. MOTHER'S MAIDEN NAME <u>Mina May Buckingham</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>216-07-4202R</u>		17. INFORMANT <u>15 Willow Avenue Westminster, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION</u> (b) <u>CORONARY ATHEROSCLEROSIS</u> (c) <u> </u> PART II. OTHER SIGNIF. COND'TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND'TION GIVEN IN PART I (e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from.. <u>MAY 12, 1967</u> , to <u>JUNE 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 12, 1967</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>William L. Stewart</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/25/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. WILLIAM L. STEWART</u>		22d. ADDRESS <u>19 RIDGE RD. WESTMINSTER, MD.</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>June 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>			
23d. LOCATION (City, town or county) <u>Finksburg, RD</u> (State) <u>Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Meyer, Jr., Westminster, Md.</u> ADDRESS <u> </u>					
25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JUN 28 1967</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08004

CERTIFICATE OF DEATH

07989

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville c. LENGTH OF STAY in lb 1 d. 23hrs.		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, d. STREET ADDRESS 170 Williams Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Charles Henry Maus		4 DATE OF DEATH 6/22/67		19	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/19	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (County & State, or foreign country) GAS & Electric Carroll Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Maus		14. MOTHER'S MAIDEN NAME HARRIET Babylon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-45		16. SOCIAL SECURITY NO 217-05-9604		17. INFORMANT Springfield Hospital Records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delirium Tremers DUE TO (b) Alcohol Intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21 I certify that (I) (this hospital) attended the deceased from June 20 1967 , to June 22, 1967 , that (I) (we) last saw the deceased alive on June 22 1967 , and that death occurred at 12:35 AM from causes and on the date stated above.					
22a. SIGNATURE <i>San Subias</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6/22/67	
22c. PHYSICIAN'S NAME (Type) San Subias		22d. ADDRESS Springfield Hospital, Sykesville Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-24-67	23c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery	23d. LOCATION (City or town) (County) (State) Westminster Carroll Md		
24. FUNERAL DIRECTOR John E. Myers Jr. Westminster, Md		25a. REC'D BY REGISTRAR DATE JUN 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5-10-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

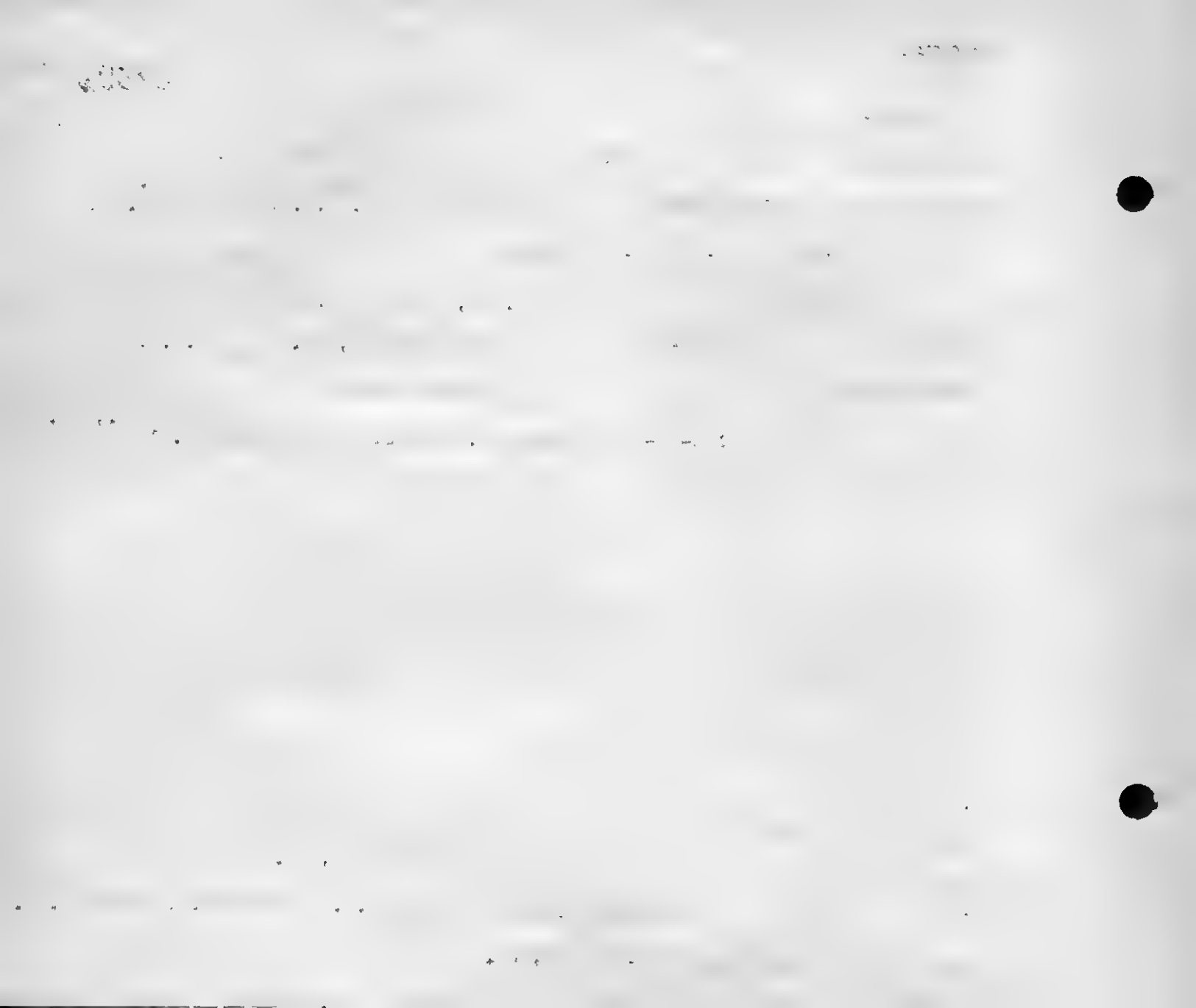
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08005

07990

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middleburg c. LENGTH OF STAY IN 1b 6 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookfield Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Taneytown d. STREET ADDRESS Mailing Address Md. Littlestown, Pa. R.D.1, Carroll Co. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle J. H. Last Mayers		4. DATE OF DEATH Month June Day 13 Year 19 67	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1888 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 M. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 10b. KIND OF BUSINESS OR INDUSTRY Farm 11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Mayers		14. MOTHER'S MAIDEN NAME Maggie Harner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO 194-36-2244		17. INFORMANT Beulah M. Mayers, Littlestown, Pa. 1 Address Carroll Co., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 35 - x DUE TO (c) Pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 35 - x		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 5/1/67 , 19 67 , to 6/13/67 , 19 67 , that (I) (we) last saw the deceased alive on 6/13/67 , 19 67 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. A. Little 22c. PHYSICIAN'S NAME (Type) J. A. Little		22b. DATE SIGNED 6/13/67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Union Bridge, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 6/16/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Gardens 23d. LOCATION (City, town or county) (State) R.D.3, Gettysburg, Adams Co. Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR JUN 15 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Golden Age Guest Home</i>						d. STREET ADDRESS <i>R.D. ?</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Marv B. Morrison</i>						4. DATE OF DEATH <i>June 21st 1967</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/13/1886</i>		9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Fayette Co., Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Calvin Bryner</i>						14. MOTHER'S MAIDEN NAME <i>Eliza Ann</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Guy W. Morrison</i>				Address <i>Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Carcinoma</i> DUE TO (b) <i>Metastatic</i> DUE TO (c) <i>Arteriosclerosis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i> <i>03</i> <i>3</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 4 1963</i> to <i>June 21 1967</i> that (I) (we) last saw the deceased alive on <i>June 20 1967</i> and that death occurred at <i>4:22 A.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>H. K. Gaston</i>						22b. DATE SIGNED <i>June 21-67</i>					
22c. PHYSICIAN'S NAME (Type) <i>H. N. MARTIN</i>						22d. ADDRESS <i>Westminster, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6/24/1967</i>		23c. NAME OF CEMETERY <i>View Hope Gardens</i>				23d. LOCATION (City, town or county) (State) <i>Carroll Co., Md.</i>	
24. FUNERAL DIRECTOR <i>C. M. Waltz</i>						25a. REC'D BY REGISTRAR <i>JUN 26 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>					
ADDRESS <i>Box 241 Sykesville, Md.</i>						DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08007

07992

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION MILLS c. LENGTH OF STAY IN 1b 2 YRS, 6 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEADOW VIEW CONSV. HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER, RD #7 d. STREET ADDRESS PLEASANT VALLEY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ADA VIOLA MYERS		4. DATE OF DEATH Month Day Year JUNE 4 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12 1888
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE COOK IN INSTITUTION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME TOBIAS MARTIN		14. MOTHER'S MAIDEN NAME IDA OHLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 220-24-8562	
17. INFORMANT MARTIN F. MYERS, WESTMINSTER, RD 7 MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from APRIL 1960 to JUNE 1967 , that (I) (we) last saw the deceased alive on JUNE 4 1967 , and that death occurred at 1238 M, from the causes and on the date stated above.			
22a. SIGNATURE Daniel I Welliver 22c. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER		22b. DATE SIGNED 6-4-67 22d. ADDRESS 19 RIDGE ROAD WESTMINSTER MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/7/67	
23c. NAME OF CEMETERY OR CREMATORY PLEASANT VALLEY CEM.		23d. LOCATION (City, town or county) (State) WESTMINSTER, RD #7 MD.	
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md 21157		25a. REC'D BY REGISTRAR J. S. Myers Jr. 25b. REGISTRAR'S SIGNATURE J. S. Myers Jr.	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08008

07993

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> c. LENGTH OF STAY IN 1b <u>9 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long Meadow Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> d. STREET ADDRESS <u>Long Meadow Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth E. Myers</u> 4. DATE OF DEATH <u>June 24, 1967</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 17, 1901</u> 9. AGE (In years last birthday) <u>65 yrs.</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Wm R. Shipley</u> 14. MOTHER'S MAIDEN NAME <u>Sarah E. Shipley</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Mr. Harry Myers - Sykesville, Md.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis, acute;</u> DUE TO (c) <u>Cardiac Arrest.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>June 1966 through June 24, 67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>June 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> , 19 <u>67</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u> 22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22b. DATE SIGNED <u>June 27, 1967</u> 22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>JUN 29 1967</u>	

500

500



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08003					CERTIFICATE OF DEATH					07994	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East</u> c. LENGTH OF STAY IN 1b <u>7</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ross Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Ve... ..</u> d. STREET ADDRESS <u>R. D. 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Sophonuia</u> Middle <u>E.</u> Last <u>Pickett</u>					4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 67</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1903</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Elmer H Hood</u>					14. MOTHER'S MAIDEN NAME <u>Cora Hays</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ruth Louise</u> Address <u>...</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease,</u> DUE TO <u>Cardiac failure; Arteriosclerosis, generalized;</u> (b) <u>Gastro-intestinal bleeding, cause unknown.</u> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>6/19/67</u> <u>through</u> <u>6/25/67</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 19 67</u> , to <u>June 25, 19 67</u> , that (I) (we) last saw the deceased alive on <u>June 25, 19 67</u> , and that death occurred at <u>10:40</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u> 22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>										22b. DATE SIGNED <u>June 26, 1967</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>6/28/1967</u>		23c. NAME OF CEMETERY OR CREMATION <u>Taylorville</u>			23d. LOCATION (City, town or county) (State) <u>Carroll Co., Md.</u>			
24. FUNERAL DIRECTOR <u>J. M. Holtz</u> ADDRESS <u>Box 241 Sykesville, Md.</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				
DATE <u>JUN 28 1967</u>											

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07995

1 PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister c. LENGTH OF STAY IN 1b HOURS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister d. STREET ADDRESS R.D. #5 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DONALD L. ROBBINS, Jr.		4 DATE OF DEATH Month 6 Day 10 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15 1967
9 AGE (In years lost birthday) 3 1/2		10. IF UNDER 1 YEAR Months 3 1/2 Days 10 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GETTYSBURG, PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD LEE ROBBINS		14. MOTHER'S MAIDEN NAME EDNA IYAY PETREY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO -	
17. INFORMANT FATHER DONALD ROBBINS WESTMINSTER		Address RD #5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 525X IMMEDIATE CAUSE (a) Interstitial pneumonitis - (SDII) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		22. DATE SIGNED 6-11-67	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/13/67	23c. NAME OF CEMETERY OR CREMATORY TRINITY LUTHERAN	23d. LOCATION (City or town) (County) (State) TAKEV TOWN CARROLL MD
24. FUNERAL DIRECTOR James G. Saffell - WESTMINSTER, MD		25. REC'D BY REGISTRAR JUN 14 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

100



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any deputy is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME BY
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07996

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b Finksburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospt.		e. STREET ADDRESS R.T. 1	
3 NAME OF DECEASED (Type or print) RICHARD R. Rupp		4 DATE OF DEATH Month 6 Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE White	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 B. DATE OF BIRTH May 9, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 70 yrs
11 BIRTHPLACE (State or foreign country) Carroll Co. Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George R. Rupp		14 MOTHER'S MAIDEN NAME Laura V. Belt	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 216-03-8824A	
17 INFORMANT Emma Blanch Rupp R.t. 1 Finksburg, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO thrombosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. H. Fisher M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/67	
23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.	
24 FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.		25a. REC'D BY REGISTRAR JUN 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 6/7/67	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08012

CERTIFICATE OF DEATH

07997

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			c. LENGTH OF STAY IN 1b <u>7 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home Inc.</u>			e. STREET ADDRESS <u>none</u>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Scharer</u> Last <u>Scharer</u>			4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1898</u>	9. AGE (in years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Mike Scharer</u>			14. MOTHER'S MAIDEN NAME <u>Theresa Salbeck</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-24-2130</u>		17. INFORMANT Address <u>Mrs. Margaret Scharer (Wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left lung</u> DUE TO (b) <u>metastasis to brain</u> DUE TO (c) <u>Diabetes mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>65</u> , to <u>6/1</u> , 19 <u>67</u> , that (I/we) last saw the deceased alive on <u>5/26</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.					
22a. SIGNATURE <u>W. H. Foard</u>			22b. DATE SIGNED <u>6/1/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard MD</u>			22d. ADDRESS <u>Manchester, Md 21102</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Manchester Carroll Co. Md</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Tipton - Eline Funeral Home Hampstead, Md.</u>			25a. REC'D BY REGISTRAR <u>JUN 5 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08013 CERTIFICATE OF DEATH 07998

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Md</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton, md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home. 128 N. Main. Monkton, Rd.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>M.</u> Last <u>Seabreeze</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 6, 1894</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Davis</u>				14. MOTHER'S MAIDEN NAME <u>Laura ? Montgomery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-6042A</u>		17. INFORMANT (husband) <u>Carroll L. Seabreeze</u>		Address <u>Monkton Rd. Monkton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO (b) <u>Arterio-sclerotic C.V. Disease</u> DUE TO (c) <u>marked Cerebral Softening</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs.</u> <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> , 19 <u>67</u> , to <u>June 11</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>June 10</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Maurice C. Carter</u>				22b. DATE SIGNED <u>6-11-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>M.D.</u>				22d. ADDRESS <u>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>				25a. REC'D BY REGISTRAR <u>JUN 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



CERTIFICATE OF DEATH

08014

07999

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 4 Westminster</u> c. LENGTH OF STAY IN 1b <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 4 Westminster</u> d. STREET ADDRESS <u>Westminster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Margaretta</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1967</u>		
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-26-1890</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>77</u> Days <u>77</u> IF UNDER 24 HRS.: Hours <u>77</u> M.n. <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Hesson</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Myers</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>770</u>		16. SOCIAL SECURITY NO. <u>212-16-9158</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>Hypertension with complications</u> (c) <u>Cerebral Vascular Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>several</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>several</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 24, 1967</u> to <u>June 22, 1967</u> that (I) (we) last saw the deceased alive on <u>May 27, 1967</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>William Speisher</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>William Speisher</u> 22d. ADDRESS <u>6-24-67</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>6-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kriders Cemetery</u>		23d. LOCATION (City, town or county) <u>Westminster, Md.</u> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Myers Jr.</u> ADDRESS <u>Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

200



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08015

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08000

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 37 yrs. 6 mo. 21 da.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) Harry		4. DATE OF DEATH Month 6 Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unkn.
9. AGE (in years last birthday) 60?		10. FUNDING YEAR Months 30 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY Paperhanging	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Springfield State Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) coronary arteriosclerosis and DUE TO (c) coronary artery thrombosis		INTERVAL BETWEEN ONSET AND DEATH minutes years minutes	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. L. Spencer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. L. Spencer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 6-30-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5th, 1967	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR Frederick D. Miller, Inc.		25a. RECEIVED BY REGISTRAR JUL 5 1967	
25b. REGISTRAR'S SIGNATURE Frederick D. Miller		25c. REGISTRAR'S SIGNATURE Frederick D. Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b Unknown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jones Motors Parking Area - Mt. Airy						2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Unknown Md. b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown Adelphia d. STREET ADDRESS Unknown 9907 Laconia Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) John			First Easterly Middle Sproles Last Sproles			4 DATE OF DEATH Month June Day 6 Year 1967					
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 28, 1923		9 AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY				11 BIRTHPLACE (State or foreign country) Shores, Virginia		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dr. John Sproles				14. MOTHER'S MAIDEN NAME Grace Pupugh							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16 SOCIAL SECURITY NO 224-24-8503		17 INFORMANT Mrs Grace East		Address 9707 Laconia Drive, Adelphi		Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 916.5 IMMEDIATE CAUSE (a) Fatty alteration of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carbon monoxide inhalation										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Terminal burning due to conflagration in automobile							
20c. TIME OF INJURY Month, Day, Year Unk Hour a.m. Unk p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Mt. Airy (County) Carroll (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.				EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				22. DATE SIGNED 6/6/67			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF June 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Stemp Cemetery		23d. LOCATION (City or Town) Sugar Grove, Smyth Co., Vir (County) (State)			
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.						25a. REC'D BY REGISTRAR JUN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



08017

CERTIFICATE OF DEATH

08002

1 PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 35y. 10m. 26d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Katharyn E. Steet		First Middle Last		4 DATE OF DEATH 6 6 1967		Month Day Year	
5 SEX female		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 12/08/01	
9 AGE (In years last birthday) 65		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME John Steet		14 MOTHER'S MAIDEN NAME Hilda Swift			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 216-03-3106T		17 INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible diabetic acidosis DUE TO (b) Dehydration DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH days days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, chronic undifferentiated type.						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		21. I certify that to (this hospital) attended the deceased from 7/10/ , 19 61 to 6/6/ , 19 67 , that he (we) lost the deceased alive on 6/6/ 19 67 and that death occurred at 6:35 A.M. from causes and on the date stated above		22a. SIGNATURE <i>Naci N. Buyukunsal</i> 22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.	
22b. DATE SIGNED 6/6/67		22d. ADDRESS Springfield State Hospital Sykesville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-7-67	
23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.		24. FUNERAL DIRECTOR Harry W. Hacht		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE JUN 12 1967		25d. ADDRESS Sykesville Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66



08018

CERTIFICATE OF DEATH

08003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 21 days		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 530 Beall Avenue	
3. NAME OF DECEASED (Type or print) LEO		Middle LEONARD		Last SWANN	
4. DATE OF DEATH 6 - 7 - 67		Month 6 Day 7 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-02		9. AGE (In years last birthday) 65 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper/Gardener		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Swann		14. MOTHER'S MAIDEN NAME Fannie (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO (b) Cirrhosis of the liver DUE TO (c) Bronchopneumonia					INTERVAL BETWEEN ONSET AND DEATH Days Years Days
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with alcohol intoxication without qualifying phrase.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that the (this hospital) attended the deceased from 5-10-67 , 19__ to 6-7-67 , 19__, that the (we) last saw the deceased alive on 6-7-67 , 19__, and that death occurred at 6:45P M, from causes on the date stated above.					
22a. SIGNATURE Agustin del Campo		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-8-67	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. FUNERAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/67		23c. NAME OF CEMETERY OR CREMATORY Rockville	
23d. LOCATION (City or Town) (County) (State) Rockville, Maryland					
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR JUN 12 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68005

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminister</u>		c. LENGTH OF STAY N 1b <u>3 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita give street address) <u>Cooney Route 94 + Mary Ave</u>		e. STREET ADDRESS <u>177 Franklin Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Larry</u> Last <u>Webster</u>		4 DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1957</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 3, 1958</u>
9 AGE (n years last birthday) <u>8</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Lawrence W. Webster</u>		14 MOTHER'S MAIDEN NAME <u>Harrnett H. Long</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>Lawrence W. Webster</u>		Address <u>177 Franklin Ave Westminister Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Neck & Multiple Injuries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>fallen from front of bus into path of oncoming car headed north</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II if then 18) <u>fallen from front of bus into path of oncoming car headed north</u>	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>—</u> p.m. <u>6/29 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, shop, etc.) <u>Route 94 + Mary Ave</u> 20f. (City or town) <u>Westminister</u> (County) <u>Carroll</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William Speicher</u> M.D.		22. DATE SIGNED <u>6/29/67</u>	
EXAMINER'S NAME (Type) <u>William Speicher</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, city or town, or county) <u>135 E. Main Westminister Carroll</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cmt</u>	23d. LOCATION (City or Town) (County) (State) <u>Rural Westminister Md</u>
24 FUNERAL DIRECTOR <u>J. E. Myer, Jr., Westminister, Md.</u>		25a. REC'D BY REG-STRAR DATE <u>JUL 3 1967</u>	
		25b. REG-STRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08020

08008

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Church St.</u>				d. STREET ADDRESS <u>Church St.</u>			
3. NAME OF DECEASED (Type or print) <u>Millard</u> First <u>H.</u> Middle <u>Weer</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-1885</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James R. Weer</u>				14. MOTHER'S MAIDEN NAME <u>Ruth M. Tucker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Mr. James Weer - Balto., Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enderteritis obliterans involving both hands - both feet</u>							
19. INTERVAL BETWEEN ONSET AND DEATH <u>104m</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>7/June, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/June 1967</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm H. Lawson, Jr</u>							
22b. DATE SIGNED <u>7/June/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>Wm H. Lawson, Jr</u>							
22d. ADDRESS <u>Box 54 RD #2, Sykesville, Maryland - 21784</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>6-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	
23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>				23e. REC'D BY REGISTRAR <u>Johnas Judge</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				24b. ADDRESS <u>Sykesville, Md.</u>			
24c. DATE <u>JUN 12 1967</u>				24d. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Index

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08021

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08027

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead, Md 2061</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>223 N Main St</u>				d. STREET ADDRESS <u>223 N. Main St</u>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>ALBERTA</u> Last <u>WENTZ</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/94</u>	9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nicholas Rimamon</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Wilhelm</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-9944</u>		17. INFORMANT <u>John N Wentz</u>		Address <u>Hampstead, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiac Vascular Disease 5 yrs</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1953, to <u>June 29</u> , 1967, that (I) (we) last saw the deceased alive on <u>5/18</u> , 1967, and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Foard</u>				22b. DATE SIGNED <u>6/29/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D</u>	
22d. ADDRESS <u>Manchester, Md 21102</u>		22e. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hampstead Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 5 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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